HEALTH FOR ALL:

California's Strategic Approach to Eliminating Health Disparities

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Panel Transcription

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INTRODUCTION

The *California Campaign to Eliminate Racial and Ethnic Disparities in Health* launched its strategic approach on November 18, 2003 at the American Public Health Association's 131st Annual Meeting in San Francisco. The following is a transcript of the *California Campaign's* panel presentation at the conference. Co-chaired by the California Health and Human Services Agency and the American Public Health Association, the *Campaign* was staffed by Prevention Institute and made possible by generous support from The California Endowment, The California Wellness Foundation, and Kaiser Permanente. The strategy document is available at www.preventioninstitute.org/healthdis.html and www.apha.org

DR. BOB ROSS (Moderator)

My name is Bob Ross, I'm the President and Chief Executive Officer of the California Endowment, which is a foundation committed to addressing the health needs of the underserved. The issue of racial and ethnic disparities in health is smack down the middle of our interest, focus, and priorities. We are a $3 billion foundation, and it is not enough to do this work. And what we spend annually in grants is probably less than one percent of what the state spends annually in the Medicaid program. So to give you a sense of how $3 billion is not enough, it is a rounding error on the state budget, in terms of state spending, that is public spending in health.

This will help inform our work, and inform our thinking, to be a bit smarter and more intelligent about resources that we invest to move this work. This is a critical, critical conversation about how to address what has got at least 400 years of history in it, the issue of racial and ethnic disparities in health, in the state of California.

Those of you that are from California will understand its importance and significance for our state. For those of you that are visitors from other states, maybe there are some lessons that you can learn from our conversation here, or thoughts that you can share with us, to make us a little bit smarter about what we want to do as we move forward.

The *California Campaign* had three things in mind when it formed in April 2001, to address California's health inequities in partnership with APHA. Three things: number one, to better understand the roots and pathways to disparities. Number two, to determine what can be done. Number three, more importantly, to set a process in motion to reduce and eliminate health disparities through some tangible and concrete action. Our partners in this were the California Wellness Foundation, Kaiser Permanente, and ourselves.

With us today is really an extraordinary group of panelists, just some of the best public health advocates, thinkers, doers, in the state, I dare say in the country. We also have Grantland Johnson, former Secretary of Health and Human Services of the State of California, and our State Health Director, the irrepressible and extraordinary Diana Bonta. They'll be sharing some comments with us towards the end.

I was actually going to do this at the end, but I'm going to take the moderator's prerogative, to make sure that we didn't gloss over something. We often have this terrible habit of not recognizing and appreciating leadership, until we eulogize them at their funeral. So I'm going to do something before that. And I want to take a moment from everyone in this room who fancies themselves and consider themselves as an advocate for health and public health in underserved communities, to express a moment of appreciation for the extraordinary leadership we've had, from Grantland Johnson and Diana Bonta.

I also want to recognize someone who is also a force in this effort, and quietly but very effectively working behind the scenes, not just to organize this event, but on this campaign strategy, and that is the Director of the Office of Statewide health Planning and Development, our friend and colleague, Dr. David Carlisle.

Let me introduce this panel for those of you who may not know them. First is **LARRY COHEN**. Larry is Executive Director of Prevention Institute, which he founded in 1997 to address complex health and social service issues. He's been a big time public health advocate, on a range of issues, particularly around prevention, prevention...I think Larry's middle name is prevention, since 1972. And there are a couple of folks that have been influencing our work at the Endowment, about how we think about health disparities. One is Larry Cohen and Prevention Institute. The second is one of our panelists, and that is PolicyLink around community building strategies. And for us it's been a marriage of folks that have been thinking about community building and community development, as well as those that have been thinking about public health approaches, and prevention, in a mind meld, and that's where the corner of 42nd Street and Broadway, where we've been living as a foundation, trying to think a little bit smarter, and more intelligently, about this work.

A quick sound byte on each of our panelists: **RAY BAXTER**. Senior Vice President for Community Benefits at Kaiser Permanente. Let me just tell you what really that means, and he may not want me to say this, but I'll say it anyway. Really, what Ray does is run a foundation. That if, in fact, you could sort of value the assets and put a box around it would be probably one of the ten largest, certainly around the five largest health foundations in the country, but among the 15 or 20 largest foundations in the country. So it sounds like a pretty nice job, and a nice title, Senior Vice President of Community Benefits, but it is an enormous amount of resources and influence, in terms of the interface between medicine and public health. And Ray Baxter, who was formerly with the San Francisco Department of Public Health, with New York City Health and Hospitals Corporation, an amazing, extraordinary thinker, and policy thinker, around issues of health and health care, and has been a great partner with us so far, at the Endowment. So thank you, Ray, for joining us.

To his right, **MILDRED THOMPSON**, who is with PolicyLink. She leads their research efforts, documenting the value of community involvement in health delivery systems, such as the federal Healthy Start program, created to reduce infant mortality. And she's just been an extraordinary leader, along with helping move the vision of Angela Blackwell, who many of you know, in making PolicyLink a real player on the health policy and community building front.

To my right is **ARNOLD PERKINS**. Arnold has been a fixture and a mainstay of community public health and community health in the state of California, probably for more years than he cares to admit, but he's been the director of the Alameda County Health Department since 1994. He's got about a $100 million budget, which is probably shrinking as we speak, and 500 employees, which is probably shrinking as we speak. But Arnold has been a forceful advocate, and great thinker and doer around the intersection of community health, public health, and health care.

To his right is **AMERICA BRACHO**, another one of my favorite people, one of our favorite grantees at the foundation, President of Latino Health Access, a non-profit organization created to assist in improving the life and health of uninsured, underserved people in Santa Ana, and in Orange County. She has a background in public health at the University of Michigan. She is an extraordinary advocate for the role of community participation in moving a public health agenda forward, and any of you that have heard her speak will know why she's a great asset to have here today.

MICHAEL BIRD, another extraordinary public health advocate, Director of the National Native American AIDS Prevention Center, a member of the Santa Domingo and San Juan Pueblo tribes, more than 20 years of experience in social work, substance abuse prevention, health promotion, and health administration. He was formerly with the Indian Health Service and was Director of Preventive Health Medicine, Preventive Health Programs, in the Santa Fe service unit, in the Albuquerque area HHS office. Again, another incredible advocate for primary care, public health, and community health, an advocate for Native American health movement.

So that is our wonderful panel. **GRANTLAND JOHNSON** and **DIANA BONTA** will be available to give some comments at the end of the panel, just to give us a sense of the politics and policy implication movement of this issue. And let's start off with Larry Cohen.

Larry, what does this thing look like?

OVERVIEW OF THE STRATEGIC APPROACH

LARRY COHEN

Good morning, everyone. I'd like to say how thrilled I am to be here, and to see the issues of equity being addressed on this statewide and national level. And I'd like to express my deepest appreciation to the current and former staff working in state government, for the enormous work that they've done, including support of this project and the report in particular.

The report really challenges the assumption that only after the fact medical services can ameliorate health problems, and by examining the critical pathways that lead to disparities in health, it really emphasizes both what can be done to prevent those disparities arising in the first place, and what can be done to ameliorate the illnesses and injuries, so that there's not a disparity in health care. I'm going to try and very quickly walk you through the report. Of course, the reports are available in the back. The *Campaign* was developed by a very large and, I think, very impressive committee. The names of the committee members are in the report.

One of the key statements comes from the Institute of Medicine, which says "All members of a community are affected by the poor health status of its least healthy members." And I think the reason that's important is both from a social justice perspective, and also from a broader perspective—when we look at issues of costs of illness and injury, when we look at lost productivity, when we look at expenditures for disability, worker's compensation, public benefits. In all those ways—and for me I would emphasize social justice—but in all those ways, we're all affected.

The *Campaign*, as Dr. Ross said, was co-chaired by the American Public Health Association and the California Health and Human Services agency, initiated in April 2001 to address inequities in health. And it's a statewide coalition, representing groups including policy, health care, public health, and philanthropy, with support from The California Endowment, The California Wellness Foundation, and Kaiser Permanente.

And as was mentioned, there were three key goals in the report, and most importantly, the third, to set a process in motion, which will reduce and eliminate health disparities in California. So the report is only the beginning.

Basically, the information in the report came out of a review of relevant literature, an analysis of related data, a consensus-based deliberative process, and interviews with key stakeholders. All that information was reviewed by the *Campaign* executive committee, and then a small subcommittee synthesized the information.

Health disparities are defined by the National Institutes of Health, as "differences in the incidence, prevalence, mortality and burden of diseases, and other adverse health conditions that exist among specific populations," and this diagram represents the trajectory from root factors to health disparities. We'll be discussing the diagram and the trajectory throughout the presentation.

We started with the medical concerns, and nine concerns were selected. And these concerns were selected, really, for three reasons. One, these are very significant health issues in California. Secondly, there's a great deal of disparity evidenced in each of these nine areas, and thirdly, these were areas where it was felt that we could do a lot. We could make a big difference in terms of those issues.

And when we talk about the issue of root factors, the report emphasizes race and ethnicity. But most important is that where race and ethnicity intersect with place and with poverty, that is to say, in low-income communities of color, that's where we see the greatest disparities.

I think one of the most unique things that came out of the group that looked at this issue was the notion of critical pathways, because there's been a lot of looking at root factors, there's been a lot of looking at disparities. But what the group thought about is what are the critical pathways in terms of both behaviors and environmental factors, and in terms of medical treatment issues, what are the critical pathways we can focus on in order to address these issues? How do the root factors, in fact, turn into the health disparities, and what do we do about that? And out of that, then, we came up with two very clear goals, and mutually supporting, to prevent the development of illness and injury, by fostering healthy behaviors, healthy community environments, and institutional support for good health outcomes. And secondly, after the illnesses and injuries take place, to reduce the severity of the illness and injury by providing high quality medical care to all.

And so, starting with the first goal, the prevention goal, we recognize that when we look at the behaviors, and when we look at the environments, when we look at those sets of critical pathways, there is a key opportunity there for prevention. And the group identified four critical behavioral pathways: tobacco use, poor nutrition and lack of physical activity, unsafe sex, and alcohol abuse.

Let me give you an example of one. What's important, as you can see when we look at physical activity and diet, is that it has an impact, not on one key disease or injury, but on seven of the nine selected areas. And we were rather rigorous with our data, because I think you could make an argument that clearly there's a relationship between physical activity and diet, and HIV/AIDS, and also with asthma.

So I think that it's very clear that when we focus on critical pathways, a good solution can solve multiple problems.

We're talking about behaviors, but one of the key questions that emerged for us is, is it just lifestyle? And this photo [photo of super-sized fast food products], by the way, represents a set of foods we collected for a study near our office on 29th Street in Oakland, for the Center for Science and the Public Interest. When we wanted to know, when you go to fast food outlets, do they say to you, "Why are you buying that little one? Why don't you super size?" We know that environment has an impact on health, but usually when we think of the impact of environment

on health, we're thinking of toxins. We're thinking of air, water, soil. And that's true. But equally, what we see is that environment has an impact on behavior, and that's another way the committee came to the conclusion: we must look at the critical environmental pathways, which lead to behaviors, which can lead to ill health. So this *Newsweek* article says, "Fat for life. Six million kids are seriously overweight." And it asks the wrong question, I think. Because it asks what families can do, as though a family can somehow solve the obesity epidemic in the United States, when very clearly there are institutions that are super sizing. And the super sizing is leading to environmental change.

Other examples. This is a jarring photo [girl standing at cigarette vending machine], which I think shows the impact of the environment on tobacco. And this is a photo taken a long time ago, when it wasn't jarring. This is a photo, in fact, taken to change the law, because then it was against the law for the 7 year old to purchase cigarettes, but not against the law for the vending machine operator to set the vending machine wherever young children could buy them, without any oversight.

Similarly, the other two critical behavioral pathways, sex, alcohol, the wild animal leaning forward to attack the woman, and she's leaning forward as though she welcomes it, because of the alcohol, no doubt. It's not surprising that this is in Spanish. And this is a photo I took—that's why it's a blurry one—this is a photo I took in the Mission District, and it's not surprising because there's far more billboards in low-income, and, particularly, in Latino communities, once again, an environmental issue, not just a behavioral issue. So the question that emerges, then, is what can we do about the environment? What are the key elements of the community environment, and that's what the committee looked at. And basically, they cluster into four different clusters, and together, 20 factors. And let me describe those to you.

First is the built environment, and that's manmade physical components, its buildings, its streets, we include land use, environmental quality, public transportation, the kinds of products available and not available in certain communities, and the style, ambiance, permitted uses, zoning of businesses and residence. We know the value of parks. We know what it means in terms of keeping communities healthy. Fruits and vegetables, according to a landmark, 2002 study, were consumed 32% more in census tracks of African Americans, where there was a supermarket available, 32% more consumption. Is that an individual decision? Is that an environmental factor?

Secondly, is social capital, the second cluster, which has to do with connections among individuals, social networks, the kind of cohesion and participation, issues such as norms, gender norms. For example, this is the *Men of Strengths* campaign, which challenges gender norms by emphasizing the positive role model that men can play toward women, and the positive role models they can play with children.

The third cluster is services and institutions, and that has to do with the availability of and access to high quality, culturally competent, appropriately coordinated public and private services and institutions, including public health, health services, law enforcement, education, community-based organizations. Literacy is key to health. Literacy is key to reducing violence, for example, and yet we must emphasize, then, whether we have the libraries, whether we have the schools, whether they're effective in every community.

The fourth category is the structural factors. And by the structural factors, I'm referring to the broad societal factors that play out in communities and may be influenced by community attention. For example, business and marketing priorities, whether institutional racism ends up getting

reflected in the local economy, advertising, promotional campaigns, the practices of organizations. This is a photo of a basketball court that when I worked in Contra Costa County, we had built in North Richmond. The funding for the court came from Nike. It was an example of one organizational practice of a business that I feel very, very good about.

So that brings us to the second goal, then, reducing the severity of illness and injury by providing high quality medical care to all. And when we looked at this goal, the two critical pathways were late diagnosis and improper treatment.

Insurance is a key component of lack of access, and is a barrier to care, and in 1999, 6.8 million Californians were uninsured. And Latinos had the highest rate, 28%. And even among Latinos who were working, the rate was only 42%. Among women, disparities get even worse. 45% of Latinas, 26% of Asian American women, as compared to only 15% of white women.

But even with care, quality matters, as the landmark Institute of Medicine report on equal treatment documented, documenting differences in diagnosis and treatment. For example, fewer cancer diagnostics and anti-retroviral prescriptions for HIV, people less likely to receive surgery for the same conditions, if they're people of color.

And culturally and linguistically appropriate services are a critical component of quality medical care. We lack a diverse work force, where the majority of medical professionals are white, far exceeding the percentage of whites in the general population.

So in conclusion, what do we do? And the National Call to Action to Eliminate Racial and Ethnic Health Disparities put it this way: "Only with combined efforts of all sectors and disciplines of society, including educational institutions, private sector, public sector, business and labor, faith community, non-profits, community-based organizations, only with the combined effort of all these sectors can we hope to eliminate racial and ethnic disparities."

So I want to end this with a very optimistic photo. This is Kaiser Permanente, in my same neighborhood, where I showed you the super sizing, and this is our Friday experience now. It's a lot healthier. And it's not just healthier for Kaiser Permanente staff, it's healthier for the community. And it's a sign and a symbol, I think, of the very specific ways that we can work together on both goals, health care goals and prevention goals.

So we have reports in the back corner, if you'd like more. It's also on our website, www.preventioninstitute.org, and soon it will be on the apha website, apha.org.

I'd just like to conclude by saying that the report is just the beginning. It's the work that we must do together that will make a difference. And frankly, I couldn't be more thrilled with who's in this room, as we turn the lights back up, and what that means about the potential of working together, and moving this forward.

Thank you very much.

PANEL RESPONSE

BOB ROSS

Larry, you were on time, in more ways than one. I think that was a phenomenal segueway, Larry, to end on that Kaiser Permanente support of that farmer's market, in that community. Let me hand this over to Ray Baxter, and I'll mention a grant that we just made...I did an event on Saturday, in South L.A., where we provided a grant to a community organization, called the Community Conservancy, and what they do is sort of rehabilitate parks. We gave them money to strengthen and upgrade a walking trail in this park, in a community that has seen a 40% increase in obesity in the last five years, among a heavily Latino and African American community.

So you see how we're beginning to think a little bit differently about how to use our resources, to advance disease prevention and health promotion, and it's clear that Kaiser Permanente is well ahead of the curve on that issue. And Ray, share us your thoughts, as one of the largest institutional health providers in the country, about this disparities issue.

RAY BAXTER

Thank you, Bob. And, Larry, thanks for the commercial for our farmer's market. We are not going into a new line of business. But we did have a meeting last week, with about 200 of our leaders and community partners from around the country, to talk about exactly this issue. What were we doing to improve community health, as opposed to deliver clinical care? And Larry showed that same slide there, and within minutes that meeting broke down a little bit. Why people kept asking, okay, where was that? How do they do it? How do they work out the parking? How do they make all the arrangements? And so forth. But it's one of those kinds of things that I think medicine has got to acknowledge, as not something nice, off to the side, but as something central to the future of health of the people that we want to take care of. This notion of pathways that was embodied in the report, is something that I think, on the face of it, once you think about it, is so obvious, particularly to people in this room that just say, you know, it took them a year to develop that idea.

On the other hand, it has a great power beyond just its explanatory power that I think is important for us to think about because for one thing, and as public health folks you think this way already, but it begins to move people out of models that are based on talking about deficits, about talking about blame, about talking about individual responsibility, and create a view of what can create health, as well as what predisposes people to disability that lets everybody start to see a place for them in participating in the health of the community. And that's a power that goes well beyond the disparities issue. But isn't it ironic that it took us focusing on disparities, to come to a conclusion that really applies to everyone in every community? The disparities issue is so powerful, and thinking about these pathways to it is so important, because it lets us start to see how injustice, how racism, how a set of conditions of isolation and discrimination and so forth, work their way all the way through a person's trajectory, either toward health or not towards health.

So let's take a kid with asthma, who, in the first place, can't get access to care, except in an emergency room. Well, let's say we manage to start addressing the access issue, either through the safety net, through community clinics, public hospitals, health departments, coverage, and so forth, and that child gets care. Now we've got a problem that that care may be uninformed. That care may be erroneous. Kids may get put on the wrong medications at the wrong point, in the trajectory of their illness. We have a problem here with lack of knowledge, and lack of knowledge getting to people who need to have that knowledge. And then even if we've got that kind of science base

for the care of that child, we can run into problems around cultural proficiency. So for example, the kid keeps coming back into the emergency room. Well, what's part of the reason? The medication says, 'no refills.' So somebody assumes that means care is over, when you've used that one up, rather than go back to the doctor, but the doctor was thinking if I put 'no refills,' that means I'll be sure to get them back, because, you know, people aren't compliant, and they don't always come back.

So we run through this kind of change of things, and we're still just in the medical care arena of this. So suppose we've now got culturally proficient care, and we've got access, and we've got ability to pay for it, and we've got scientifically informed, evidence-based care going on. And we do a great job in the examining room, with that child, and with the child's mother or father or guardian or whatever, about what needs to happen. But the kid goes back into a home where there's mold, where there are roaches, and we've got other aggravates going on in the environment. And then the kid goes to a school where, first of all, the inhaler gets taken away because that might be drug paraphernalia. And then the coach says, in the P.E. class, if they still have one, says either, "It's all in your head. Get out there and kick butt," or says, "You know what? You shouldn't exercise. Stay on the bench." Neither one of those things is right. And then we can track this on through the workplace, through regulation, through, living next to a bus depot, where you've got diesel buses idling all day long, and spewing out diesel fuels.

These are all part of disparities, and they're all part of understanding the way in which these pathways work. So I think that the power of the approach that Larry and others in the campaign developed here is an ability to see problems in a much broader kind of context. And for us to think about them in a way that says everyone can have a part in dealing with that, not just health folks, not just healthcare people, but people in business, labor, community organizations, politics and so forth.

BOB ROSS

Thank you, Ray. Another great segueway into an organization that has helped change my thinking, quite frankly, Mildred, on how we've been approaching disparities, along with...Marion Standish, our program director for disparities. Thank you, Marion, for making me smarter.

Place-based change, place-based approaches, have had success in other kinds of venues, and we're trying to cross-fertilize that success with disparities in health, and PolicyLink is at the forefront of that thinking. Talk to us about the fundamental elements of place-based approaches.

MILDRED THOMPSON

I'll be happy to. People may want to know why focus on place, and why focus on policy, and I hope to answer those questions.

My personal interest began when I was running a program called the Healthy Start program, and that was a program to reduce infant mortality. And then when I came to PolicyLink, we did a national research project on other Healthy Start programs, and what I knew basically got borne out as truth, which is that in those communities where babies were dying, two and three times the rate of the other populations, there was the same thing happening in all those populations across the country. Those populations also had high unemployment, high poverty, high crime, so that there had to be something going on in those communities. So we were really wondering at PolicyLink, how can we begin to explore what's happening in these communities, to create not only infant mortality, but other health issues. Because infant mortality was just one pathway, but communities also had high rates of hypertension, high rates of cardiac problems, and so there are some very serious things going in those communities.

And so our approach is taking a look at what is the framework by which we should begin to take a look at this work? And on the back table, there are some sample handouts, which describe our framework. And our framework is beginning to take a look at what are some of the social and economic factors that are going on in these communities?

Clearly, we know the big things. If we eliminate racism, if we eliminate poverty—you know, if everybody had a job, we'd have a much better society, not only in terms of health disparities, but in terms of a whole quality of life. But in absence of being able to do those big things right now, what kinds of things can we begin to take a look at right now? How can we take a look at the effect of race? I mean, we don't want to talk about it too much at these circles, but we've got to begin to be a little bit more deliberate in how we frame our conversations, not only in terms of raising the issue of what are the weathering effects of racism, and how that affects health outcomes, but also framing this whole discussion around health disparities. I mean, we may need to look at another terminology to use here. And so we have to begin to think about what role can we play in beginning to change the conversation.

I was very encouraged last month when *The New York Times* ran an article on the impact of place. I mean, that was very encouraging for us. In fact, we wondered if they had gotten our report and didn't tell us. But, you know, how could they not credit PolicyLink, because this was some of our prime work, taking a look at what are the place-based factors, again, taking a look at the fiscal environment. What has happened in terms of the air? I don't know if people are aware of the fact that in California, San Joaquin Valley has the third worst air in the entire country. And you know what? That air doesn't just stay in the San Joaquin Valley, it travels to other areas as well. What is going on there? Well, there's pesticide spraying. Yes, it grows some of our best vegetables, but is there pesticide spraying there? And who's working in those areas? Are they getting the care that they need? It's a cyclical issue that we're trying to address here. What is happening in terms of the quality of the air? The California Endowment had been a wonderful support in terms of us trying to work with coalitions across the state around addressing asthma policies that need to be changed. And they were so visionary, in terms of looking at some of the environmental impacts. Clearly, we need to address the clinical issues. But we also need to take a look at what are the environmental conditions, and how do you begin to change policies. How do you begin to look at the school environment? You know, again, looking at how place based are affecting health.

Many of the schools that the kids who are going to, who are poor, the schools are not well maintained, there is mold and mildew in the schools and in the homes. Kids don't have a safe place to go to school. They don't have a safe place to play outside. The communities don't have the kind of recreational facilities. When I grew up, we had a lot of girls' and boys' clubs. The mothers knew we were down the street. They didn't have to worry about where we were every moment. Many times our families do not want to have kids outside in the parks because there's criminal activity. And so, you know, there's a lack of recreational access. Those things have health impacts, so they stay indoors where there may be unsafe air to breathe in the house. You know, there may be mold, there may be housing conditions that are not being well maintained.

So you get the picture; this is not new information. But how do we begin to frame policy change to address these issues? And clearly, we can't ignore the impact of needing more health care. But what my concern is, is how can we bring health care into the community so it's not seen as an institution? How can we begin to partner with what already exists in the community, and bring health as a component of that? How can we begin to have health in the housing projects or relat-

ed programs in schools more? Health...faith-based institutions have been some of the main players of having parish nurses, or having a mobile van go to the church after services, and begin to do high blood pressure checks. How can we begin to form partnerships with unlikely partners, to begin to look at how we can change on a very basic level? How do we begin to work with existing neighborhood coalitions, to help them to rise above, and lift up what's working? People in the community know what to do. But how can we partner with them as public health institutions, as funders, as sororities, as fraternities, how do we stretch beyond our traditional roles, to begin to address the policies and the changes that can begin to make a difference in terms of health disparities.

BOB ROSS Thank you, Mildred. I assume you would see what Ray Baxter and Kaiser Permanente have done, in terms of that farmer's market, as a prime example of reaching out to an ally and an asset, in a different kind of way.

MILDRED THOMPSON Absolutely.

BOB ROSS Excellent. Arnold Perkins. Arnold is at the nexus of this work. He is at the nexus of policy and practice, and how it translates into health outcomes, in communities and in neighborhoods. And Arnold, we know you spent a lot of time thinking about and concerned about and addressing the issue of tapping into social capital to improve health. You've done some work around young men, growing up in Alameda County, and particularly as it relates to gender norms. What lessons and insights can you share with us about moving this agenda forward?

ARNOLD PERKINS Let the words in my mouth and the commitment in my heart be acceptable. I always start that way because sometimes people get offended. In my work with young men, I see a lot of angry young men who are just absolutely in full rage. And what that's all about is hurt, they're really hurt, really seriously hurt. And what we have is institutional sexism and institutional racism. What is institutional sexism? Maternal child healthcare is institutionalized sexism, because it excludes the man. This is especially true in the African American community. We have the same thing in our welfare system, institutional sexism.

So I recall growing up in the '40s. And there was a real clear role for my father and my mother. As time went on, I saw the family disintegrate. I'm going to speak for the African family, which is what I know best. What happened over time is that the government became the male. Now when did that happen? If you recall the war on poverty...as that went along, and we moved into the '70s and the '80s, we saw where the welfare department would come to your home, and make sure there was no man in the house, made sure, and that system never stopped, as it were. Maternal child healthcare is not about including the man, it's about excluding the man. That's why at my shop I refer to it as maternal-paternal child adolescent health, because the man has to play a role.

So what's the significance of the man not being there? I'm going to give you a little story. I have a friend; I went over to her house, and I was using the bathroom. And I'm a plain speaker. So I went urinating, and he looked at my penis, he looked at the toilet, he looked at my penis, he looked at the toilet. He couldn't figure out what I was doing. He was about five years old. And he sat on the toilet, just like his mother did. He didn't know any different. And if you project that out over a period of time, you see a lot of our young men are feminized, and I don't use that neg-

atively. In my generation, you kind of dealt with issues in a logical fashion. In this generation, "I'll blow you away, bang," because they don't have that kind of measured approach.

I was at a retreat last Thursday and Friday. They had us do this exercise, where we sat next to each other, and you had to look in the person's eye, and ask, "Who are you? Who are you? Who are you?" And at the very end of it, I was very uncomfortable doing that, because I said, "I know who I am, and I've told you who I was." But you do for five minutes. And so someone made a comment that said, "For females it's easy because we don't ask questions. For men, you want to know, 'Well, if I'm going to get from A to Z, then how am I going to do...?' You have to lead me through it before I'm willing to do it" A lot of our young men don't know how to be led through that because they will respond just like that. So it's had an impact. And, now, what more? We have a prison system that is set up for our young men, especially African American young men. So we make sure that, again, we have institutional sexism, and institutional racism.

And so what impact does that have on our young males? Our young males end up being lost, and many of us males don't step up to the plate, because we don't even know our community. Many of us sitting in this table will make decisions on community, and have not set foot in the community, don't have a clue. But we talk as if we do, especially us policymakers. When's the last time we've actually been in the community, on the block with the young men? When's the last time we have seen a memorial with 100 Remy Martin bottles? Many of you don't even know what that means. A pair of tennis shoes, a bible, Remy Martin bottles...what is that...? Well, it meant that good brother is going to the other side, to live the good life. Well, that's significant to them. And these little nuances in our community... And until we begin to understand the meaning of those, we will not be successful dealing with either the racial disparities or the racial inequities, because we don't know the people that we make policy for. So all that's gloom and doom.

So what do we need to do? One of the first things we need to do is to get up off of our derrieres, and spend some time with the people that pay our salary that cause us to live. All of us, for the most part, are privileged people. And we need to go and spend time with the people who cause us to be privileged, and not be afraid of them.

We also need to look at what partnerships can we develop within communities, to lift up some of the racism and sexism that our young people are feeling. How do we lend a hand to hug someone? Some of these young men, when you hug them, they're so tough and bad, but when you hug them, they just melt because no one hugs them. And those of us here who get hugs, you know how a hug feels. When someone comes up to you...and I'm a hugger...when someone comes up to you, and sincerely hugs you, it feels good. Well, they don't even have a hug, so that means mentorship programs, that means friendship programs, that means neighborhood youth corps. If the Endowment gave me a bunch of money, I'd set up a series of neighborhood youth corps, where the youth in that neighborhood are involved in doing community gardens, involved in painting fences, involved in doing a number of things in their own community. Many of these young people don't like their communities, even though they say this is my block. They don't like being where they are, but all they have is that block. They don't own anything in that community, but it's all they know.

We also need to look at some of the policy work with the community to develop policy around alcohol issues that's just dumbing our young people out. We need to look at recreation opportunities. I tell you, you need to exercise, and that might be telling you something dumb because

you might be killed. And that's just like when I was working with a lot of young people. Some people would come...you need to take off that bulletproof vest. Dumb. You need to keep it on until you've changed your life. And so we need to begin understanding these things, we need to begin working differently with our young people, because I wouldn't do the work if I didn't believe we could make a difference. And if we partner with communities, equal partners, not as these government gods or whatever, non-profit gods, but as equal partners, and learn from them that wisdom exists, just like Mildred said, "The wisdom exists within the community, and we have to figure out ways of listening."

BOB ROSS

Thank you, Arnold. I think we've heard an excellent summary of the elements of a community building, social capital approach to addressing the issue of disparities. I also think that a proposal's going to come in from you on Monday, Arnold, to the foundation.

I got to tell you, I'm intimidated by the thought of moderating a panel that has back to back, Arnold Perkins, America Bracho, and Michael Bird, but here we go. Because they're together no one will have to go to church on Sunday, because you will get all spiritual wisdom and energy and passion from this trio. America Bracho, you've done an extraordinary amount of this kind of work. I think you're a perfect segueway from Arnold Perkins. Talk about the thoughts you have about what needs to be in a long-term campaign, to address the issue of disparities.

AMERICA BRACHO

I'm going to talk a little bit about the importance of community participation, and involving residents in decision-making in their individual health, their family health, the community health.

As I was reading this report, and the emphasis in developing comprehensive strategies, I couldn't avoid thinking that this is what we have been saying about HIV for many years now. When I was the director of HIV programs for the Latino community in Detroit in 1988, which was the first program on HIV for Latinos, in spite of the fact the epidemic started in 1982, and people didn't know why we didn't know anything about HIV in Detroit. The women that we saw in our program were all Puerto Ricans, they all were using drugs or having a partner that used drugs. They all had a history of rape, or sex, sexual abuse, and we all started talking in this nation about the importance of addressing this epidemic from that point of view as well. We all said, there is this connection about drugs and women that we need to address. They are dating or they are living with men that are on drugs. There are no treatment centers; there are no treatment centers that accept kids. These women are not involved in decision-making, it wasn't important.

So the comprehensive intervention started to come. Oh yeah, we need economic development and how economics affect these women, and how these affect women and domestic violence. Many years later, the reports got bigger and more comprehensive, but the strategy was the same, condom use. Because at the end of all of this, everything is reduced to something that people feel comfortable with. Comprehensive strategies make people feel uncomfortable because we do not control the evaluation process of that, and we do not trust that the community can do it.

When we talk about community participation, and when we really truly involve the community in these strategies, the community keeps us more accountable than anything else. There is no one evaluator that has worked for NIH or any other organization that can make this promise more accountable, than a mom that is committed to a program for their kids. When they are involved, this is not going to disappear when funding goes away. So this really is what makes programs

accountable. Community participation, when it's real, is your main investment in accountability. It's your main investment in sustainability. And what community participation is right now, like multiculturalism and all those words people just use, driving me crazy. People talk about participation and you ask them, give me an example what participation is. When I interview 10 people in my street, they are participating. Well, I'm not sure. What is the difference between a survey and community participation?

So community participation is when, truly, you involve people in creating a mechanism for themselves to define change. When we stop defining change completely, and we become part of the team defining change. When we acknowledge that there is a group of residents that live in that community that has asthma, and is dying of injuries and all of that, and we think that they could have a voice, and need to have a voice, and define the change.

But community participation, when it's done right, creates also a mechanism for people to share assets and talents, to make that change possible. And that's the other problem with many of these things, is that we don't believe that poor people can have assets or talents, that people that don't know how to read actually could help kids with homework. You know, and we could have plenty of stories of grandmas that just say, "Just do your work." You know, and they do it. And that grandma doesn't know how to read, but the kids are so afraid. There are ways in which we can support things to happen. Our mind is like, "These are the talents, these are the assets that can influence change," and that is not true. Therefore, we don't create those mechanisms.

But community participation helps people with a voice, helps people with creating mechanisms, helps people to think, which is critical. What we do here in this room is to think. And what these reports do is to help us think so we can engage in action. What makes these communities different? They need to think, so they can engage in action. And what happens when we engage in action is that people think again. And then people engaged in actions are more mature, more focused, more directed, with more resources, because now they are learning. And you know what happens when people think and change, and think and change, and actually things change? Then people become hopeful. Nothing of what we are doing can be done if we remain without hope in these communities. What fuels the interventions in these communities is the hope of that mom or of that dad, of those parents.

I believe that this pathway concept is a very good one, is the one that we try to use at Latino Health Access. And I find that there are many, many pathways; that it's just a matter of connecting with what you have in your community.

Yesterday, the director of Saddleback High School in Santa Ana, which has 3,100 students...can we imagine a high school that big...came to us, at Latino Health Access, and said, "I have a problem, because parents do not participate in my high school. Can you bring something so they can come?" And actually, my response, which is even more motivated today than it was yesterday, is that parent participation is a pathway. And my answer to her was, "Why don't you create a healthy community in your school?" You are saying that parents cannot come because they have little children. Then do things for little children. You say they don't come because they have to go to English classes. Do the English classes in your schools. I mean, you have a captive audience where you can do so many things, but you have to trust that parents have something to give, not that you need them so you can report that parent participation increased 10%. So...how do we see community, how do we use it? No, how do we include it?

So I think that in the other part of this, we have to somehow design strategies that people can own, and if we talk about the other goal of this report as influencing medical care, and the quality of life in terms of absence of disease and all of that, then the decision making also has to be improved at the individual level. And it's not going to be improved with health education programs and advice that are obsolete, that are boring to death. I can't believe that we continue explaining condom use in the way we do, with fingers and stuff. That's horrible. We do it with youth. Can you imagine who's going to pay attention to that? You know, and we talk about diabetes, talking about metabolic disorders, when diabetes is something that affects the life of people. This is a personal and social experience. These are diseases that affect. I'd rather listen to my uncle in Guadalajara, or my grandma in Puerto Rico, and their advice that is more realistic and more in tune with my feelings than a doctor that is only thinking reducing tortillas as a mantra. I want to know about diabetes, so I can influence my treatment. I want to take off my shoes and be able to tell my doctor, "Will you look at my feet, please?" So I think that probably the first behavior we need to influence is the behavior that will lead this community toward more participation.

BOB ROSS

America, you're like Mother Theresa and moms maybe, rolled up in one. It's impossible to hear America without laughing and crying simultaneously.

Michael Bird, tremendous amount of work and experience on this issue. And some of the issues have now rolled up, I'm sure, actually, into another important segueway. Community participation, ownership, change, strategies...tell us about your experience in HIV and AIDS, and what translates out of that experience, into helping making this campaign smarter, for what we need to do.

MICHAEL BIRD

Good afternoon, and welcome, and I very much appreciate this opportunity to be here with you this afternoon. I need to mention that I once was president of this...an obscure organization called the American Public Health Association, and the first American Indian in the history of the association, so if anybody knows anything about disparities, hey, stand up, we all know. But we're all in this together, nonetheless.

I do have to mention very quickly that for those of you who don't know or may have forgotten that in this nation, November has been defined as the Native American Heritage Month. And so when all of you are sitting down to your Thanksgiving turkey, and with your family and friends, I expect a call and an invitation for dinner, because if it was not for the first Americans, none of you would probably be here, and none of you would have done as well as you have. And a price has been paid. The fact of the matter is in this nation, you know, some people, some people got a country. We got a month. Go figure. And the fact of the matter is in this nation, today, and this applies to many populations, but clearly American Indian populations, indigenous populations, all across the globe, be they Maori, be they Native Hawaiian, be they Canadian aboriginal people, be they Australian aboriginal people. The fact of the matter is the dispossession that occurred throughout the world, over 500 years ago, in fact, has set into motion many consequences that indigenous people and many other people have to live with today. When you dispossess people of their land, their language, their culture, their tradition and their religion, and this happens to many other populations as well, it sets into motion forces that have long-term implications and long-term negative impact.

For native populations, to this day, one of the issues that we clearly see in many of you is just the lack of visibility. I don't know how many meetings I have to attend with CDC and HRSA, and

they'll say, "Well, there's not enough of you. You don't have the numbers in terms of HIV and AIDS. You're not demonstrating the kind of numbers that we need to see before we can really begin to pay attention." You know what my response is? "Well, there used to be a lot of us. Do you want to go there? Do you want to have that discussion?" In fact, 100 million native people in North and South America died as a result of contact. This is all documented. David Stennard's *American Holocaust*.

The result of that impact, the result of that dispossession, is a legacy that we live today. When people talk about homeland defense, who knows more about homeland defense than American Indians? We've been defending our homeland for over 500 years. And quite frankly, haven't been getting much help. We believe in homeland defense. But when you defend your homeland, what and your home, what are you defending? Why do you defend your home? You defend it because of the people in your home—the people in your home—which means you invest in the people. You invest in their health, you invest in their education, and you invest in their well being. Anything other than that is not homeland defense.

Also, I would say that the whole notion of so many of the problems that we're dealing with and the rhetoric that we hear today, in terms of we're talking about faith-based. Native populations believe in faith. I mean, the first prayers in this land were given, and continue to be given to this day by native people. They prayed for their families, they prayed for the land, they prayed for the earth, and they prayed for their crops, and they prayed for people all over the globe. They still pray today, for everyone. That is real faith. That is a real belief in the humanity and a conscious humanity of the fact that we all share this globe and this world together. That is something that some people have forgotten.

When it comes to personal responsibility, which is just such a big joke, those of us who were not born with silver spoons in our mouths, myself, many of you included, when somebody's going to tell me, come to me, and preach to me about personal responsibility, you know, let's talk about personal responsibility. Those of us who come from disadvantaged, those of us who come from homes that were broken, by substance abuse, and a number of other sorts of issues, we know about personal responsibility, because we would not be here today if we had not demonstrated some sense of personal responsibility.

The fact of the matter is, in so many of our communities, there's a real sense of hopelessness. And where there is no hope, there is nothing to work. It's very, very difficult to inspire people, once they reach that state of hopelessness. But then again, let's also remember that there is a world community, holistic concepts did not come from public health. Holistic concepts of the way we see the world, came from indigenous cultures all over this world. In the words of Chief Seattle, "All things are connected." We're beginning, even public health is beginning, to recognize, and some people in the world are beginning to recognize, the wisdom of indigenous values, culture, and tradition. There are many answers that lie within. And I think the fact that we have marginalized, diminished the value of much that is inherent in our culture, much we already know, and recognize to be true, is such a fallacy.

The other thing I would say, and it was mentioned earlier, is there are many people, I think it goes back to the community. If an effort does not benefit a community, if an effort does not benefit a population, then it is not worthy of any kind of support. There are many university programs that are being funded to do all kinds of work, with many communities, and what you end up build-

ing is little empires that benefit a small segment, a small elitist sort of clique. If it does not benefit the community, it is not worthy of support. And if you're involved in that kind of activity, then you need to step back and take some responsibility and do something different, or get out of that community, and allow them to identify and find people that really will build that community.

The public health community, we need to be more accountable to ourselves, and to the community that we serve. We need to step back and say, how honest are we in terms of what we do, in terms of our behavior, in terms of our approaches to working with communities, looking at our own issues of racism, elitism, and power and privilege. Because ultimately, in my experience at this point, what I have discovered, after being in public health for much longer than I ever expected, is it really boils down in this nation to power and privilege and politics. The next president of this country probably will be the person who has the most money to spend on television. It won't be based on necessarily their merit, their intelligence, their heart, their passion, or their commitment for the community, and the people of this nation. It will be based on solely one thing, and that's how much money they have in their bank. God bless America.

BOB ROSS One sentence or less, action steps that have to happen, moving forward from your vantagepoint. Larry?

LARRY COHEN In the words of Dr. George Albee, "No epidemic has ever been resolved by attention solely to the affected individual."

RAY BAXTER Approach partnership with respect and humility.

MILDRED THOMPSON Eighty percent of our poor health outcomes are the result of 20% of populations. And only 10% of health disparities are the result of poor health access.

ARNOLD PERKINS Work with the community and not on the community.

AMERICA BRACHO I believe a lot in local action. And I think it's that local action, and that local inclusion that can demonstrate that these things work, and, of course, keeping the connection with the state, and the national and the policy, but the local action. So I believe that we need to build capacity in our communities, and we need to demonstrate that comprehensive strategies can work. That we need to engage everyone in that community, and provide mechanisms for them to be hired, and paid, compensated. When you have 40, 50 people, whose job is to transform their communities, watch, because things start happening.

I think that we also need to work on representation. We sometimes are being represented by people that speak English, and that's the reason why they are representing us. There's nothing else that links them to the community or the reality. But we can't continue just saying, well, let's send him to represent this community and me to represent my community, forever. We also need to build that capacity, so other people can start talking on their behalf, of these communities, so to build capacity for representation is extremely important.

We need to find the people that are isolated in our communities, and include them in programs, in spite of the fact that other organizations keep saying that they can't find us. Then we need to find ourselves. And tell them, here we are.

And finally, I think that we need to work on common ground with other institutions, hospitals, universities, schools, so we can move common agendas forward, because without that common ground, unity is not going to happen.

MICHAEL BIRD

A couple words and then one quote. Passion and heart, wisdom, action, and results. And then the one thing I would say, Albert Einstein was quoted as saying that "Creativity is more important than knowledge." And I think we need to remember that. Creativity is more important than knowledge. Knowledge, in and of itself, can oftentimes be static. Creativity is unlimited. We have not tapped the creativity of our communities, and of this nation, and of the world.

AUDIENCE QUESTIONS

BOB ROSS

A hand for our panelists.

Here's what I want to do. I want to spend 10 minutes in a lightening round of any questions or burning comments. Speeches are wonderful, but not a speech. A sound byte, or directed question.

AUDIENCE MEMBER 1

I'm from New Jersey, and I'm interested in the fact that the document is called Health for All. This is the mantra of the WHO effort, from 1978. As far as I know, it has never been done in the United States. I had the experience of implementing it for 10 years in Ghana, and I saw all the results, by incorporating, really...the focus being the local community taking the effort to do it. So are you calling for that strategy? And I hope so, but anyway, it was very wonderful. I was just interested, who got that first three words on the report?

LARRY COHEN

There was a lot of discussion about what the appropriate title would be, and we really wanted to keep a focus on the fact that inequity is unacceptable. And we want, as Mildred said earlier, to figure out the kind of words that will change that. Really, it was Marion Standish of The California Endowment, who suggested the Health for All title, to go with the disparities, so that we could really talk about inequity, but emphasize that it's got to be health for everyone, and everyone is affected by inequities among us.

BOB ROSS

In adding to that, as was mentioned, the Canadians and the Brits, in particular, are way ahead of us. There's a whole bunch of folks that are well ahead of us on this curve. Lester Breslow, godfather of public health, said, "This is the next challenge for public health, going from infectious disease, chronic disease prevention, health for all." We see this effort at The California Endowment as a pathway to getting to health for all.

AUDIENCE MEMBER 1

But it's the community-led piece of it that I mean. I meant in the sense that we've never done community-led, so we've been oriented or you label it or you get your representatives, but we never do it from community-led. And this is the wonderful experience that's being shared...all these things. That's what we need in this country.

AUDIENCE MEMBER 2

It was a great panel, a really, truly stimulating panel. One of the things that we've been struggling with in Alameda County is how to get the work done in the community at the local level. And one of the things we've been considering is partnering with real experts in this, organizations that do community organizing, because in public health we have epidemiologists, we have physicians, we have nurses, we have outreach workers, but we don't really have people who have the skills to do community organizing, and I think we have to accept that we don't know how to do this. And I'm hoping to hear a little bit about the experience of some of the panelists, in actually partnering with organizations that do community organizing, so that we can learn from them, and not try to do everything ourselves.

MILDRED THOMPSON

Well, I just wanted to mention that the work that we're doing with The California Endowment, of working with asthma coalitions across the state. I know I saw Nancy Ibraham in the back, and she's working with some really wonderful, the Promotores program in Los Angeles. There are a lot of programs that actually have their hands on the pulse of what needs to happen in the community. And so being able to link with those existing communities, I would certainly recommend that. And also there is a listing of the PolicyLink reports out there in the back, and there is one, which talks about some problems and practices that you could also use as a guide.

AMERICA BRACHO

I think that it's true that many of the institutions, such as the health department, they don't know how to do this work. And the thing is that sometimes they look for partners in the community, which I think is the way to go. So they want people doing something, but they want to define that. So it's like they know that the experts are there, but they want to be the experts. So what happens is that sometimes they hire the services of community workers and promotores, but the supervisors continue to be in the health department. So now the supervisor is telling this new person how to do business, which they don't know. And you end up with two people not knowing what to do. So it's not only who is your partner, but how to partner that needs to be explored, and accepting the fact that this organization is providing expertise. Therefore, they need to be part of the plan. And they need to be heard in terms of what works, and what doesn't. And that we need to define, also, who, then, is in charge of supervising this type of work, if we want it to be different.

Finally, I think that we know how to assess when you can organize a community, when the work is being done with quality, because in spite of the fact that we are sometimes in these institutions, there was a time in which we knew how to talk to people. There was a time in which we saw the value of having a coffee, or just spending time with people. And we are removed so far from that that now we need to rely on people from the community, to learn how to start a conversation.

And so I think that how to assess these interventions needs to be fueled by common sense, and then let the partners guide, too.

RAY BAXTER

Just one quick comment. There are people who see community as a means to an end, not an end in itself. And if that's the way people are approaching it, it's not going to work. The community is not going to benefit; the community is not going to grow. When you work with real community, you build the community. You increase their competency; you increase their skill. They don't need you. You don't want to be doing this power trip, where they become dependent upon you, and need you. You should move to a point where you can leave, and they don't need you.

AUDIENCE MEMBER 3

I had a question about your implementation, which you stated was your next real work. And I was curious, do you have any thoughts, having to build off of this, on whether you're going to be looking for more foundation support for some new programs, your key triggers on policy. Can you kind of lay out your map of where you're going?

BOB ROSS

Larry?

LARRY COHEN

Bob? We're not going to quit until we get the work done. And I don't know how we're going to do it. The group that pulled this together needs to now say, "We've done this. This is fine. This is paper. We have a strategy we must implement." It needs the support of every single person in the room to spread the word, to build the momentum, and to figure out how to translate the strategy into action. I think it's very clear from this report that we need key institutions. That includes government, it includes foundations, it includes the business community, it includes the healthcare community, in particular, but not solely. And exactly how we come together, and what we do next, I'm really not sure, but we're going to do it.

AUDIENCE MEMBER 4

I was a member of the committee on the future of the public's health in the 21st century, and one of the major issues that we covered in the report was that the key to assuring the health of the public is multi-sectoral collaboration. And it speaks to this whole issue, and I believe deeply in what the panel has spoken to. And I wish to express, though, that we must not only collaborate with communities who are affected by disparities, but also to the corporate community of America. The business of our country is business, it's what moves politics, it's what moves policy, it's what buys and sells to many of our communities. And maybe Ray or maybe others of you could speak to this, as to how, then, do we engage in dialog with corporate America, to take responsibility for the conditions that exist in our communities, and to take a leadership role in changing the environmental conditions, the social conditions that lead to disparities, because this is where even more important and effective dialog can take place than in this room.

RAY BAXTER

I'm not sure I've been the most successful person in my career in talking to corporate America. I think there is an opportunity here, which is, by talking about health in the broad kind of terms we've been talking about in this room today, that it does create different ways of talking to organizations and institutions, about what their accountabilities are, and about what they actually can do.

Too many corporate people that I talk to, and it's not like I spend my life talking to them, have been put in a position, in a way, now, where they think, unless they offer health insurance for their employees that that's the central issue, is do they offer coverage, how much is it costing them. That's the conversation that they want to have. Nobody's talking to them about the food they're serving in the lunchroom. Nobody's talking to them about transit passes instead of everybody driving. Nobody's talking to them about workplace safety issues. But far away from wellness

issues, about basic safety practices and so forth, no one is talking about how investing in vulnerable communities can make a difference in health.

So I think there are opportunities. I don't have any illusions about working with corporate America, or corporations, in any of our communities. But I think we have to change the nature of the conversation, and get back to the things that drive their businesses, and treating them as parts of communities, whether they see themselves that way or not. Their work force is in communities. They are in communities. And we've got to draw those connections back again, in a way that makes some visceral sense to them, and then I think there's an opportunity to have the conversation.

CONCLUDING COMMENTS

BOB ROSS

Terrific. Let me hand this over to Diana Bonta. Diana, I hope you have a couple comments you'd like to share. And then I'm going to hand the wrap-up over to Grantland Johnson, who's a great thinker, doer, on these issues, but Diana, come on up.

DIANA BONTA

I was trying to put my thoughts together as you were talking here. And I just want to say a couple of different things. First of all, this panel gives me courage. It gives me courage that California will be okay. Because they are fantastic. So that's the first thing I want to say. And I know Grantland will join me in that spirit, as well.

The second thing is, and I was thinking about the medical priorities because, you know, we can't get away from that medical model, too. And I want to suggest that we look again at it. You can't put everything on it, but I was a teenage mom myself. I know that we have had tremendous successes here in California, throughout the country, in terms of teen pregnancy. But the issue's not going to go away. We have a boom of teenagers that are going to be out there, and there will be pregnant teenagers. So I would suggest that that be something that be included in there, even if you have to get to 10, in terms of items.

And I suggest that, with respect, many of the men involved in these teen pregnancies are men in their 20's and 30's. They are not teenage boys, but they once were teenage boys. And as such, we need to involve them in this. So with all respect to my colleague, yes, you are so right, we need to involve the men in there.

When I was in Long Beach, I learned from the community, in terms of a project that we had together, called Proud Fathers of the Hood. And it was to involve men in their relationships with their children. Many of the women they were no longer partners with, but it didn't mean that they should be excluded from the lives of their children. And the way to do that was to be able to bring them back into the fold. And I remember, as our staff, we were trying to look at what would be incentives for these men, to be involved, and first, people came up with, car washes, and other kinds of things, where they can, you know, get them as rewards for this participation. The

men taught us the lesson. They said, "Give us some money to buy some baby clothes," to come back into the community, to go to that mother, and to say, "I want to be a part of this child's life. We didn't make it. We're not together, but it doesn't mean that I have to be excluded." So let's do that. Let's look at teen pregnancy in a very new manner.

I learned, also, from that community, from my Asian brothers and sisters. And in that I learned, and I think you should read, all of you, if you haven't read it already, *The Spirit Catches You and You Fall Down*, because it is such a powerful illustration of what we do wrong in health care services constantly. And it is a powerful remembrance of how we approach families from our point of view, and not from theirs. And it is a powerful reminder that cultural, ethnic disparities, that words are not just words, that cultural competence is not just a sort of theoretical discussion, that we must change the dynamics of how we are doing our work.

We had a transit strike in Los Angeles, for over 35 days. Yet there will be people in health care institutions who will say, I don't understand why so and so never got in to see the health provider. Just go out to the street and you'll understand why they didn't get in to the health care provider. They could never make it. I want to see those corporate vans and everything else, joining forces, that we would have picked up some of those people from the streets, and brought them into their medical providers, but we didn't think about it, because we don't think at the time, when people need it, in crisis. We're always responding too late, too little. So I want to see those changes as well.

And lastly, I'll say that APHA needs to learn from this. This should be a session that's held with thousands of people in the room. This should have been the panel in the opening session. This should be the conscience of us, of what we are about at the American Public Health Association. This should be taped and played for other generations of young health care professionals, so that they don't make the same mistakes that we have made, in our course and our path, but you still make me damn proud. Thank you.

BOB ROSS

Grantland Johnson, friend, colleague, mentor, leader.

SECRETARY GRANTLAND JOHNSON

Let me say, this is really an exciting panel. And it was exciting to work on this project, as a co-chair with Dr. Benjamin.

Let me, first of all, start out with a confession about some of the agenda that we had at the Health and Human Services Agency. And as a way of sort of transitioning into my comments about how we view this particular report, because it is a work in progress. We first came on board in 1999. The framework that we wanted to proceed from [was] the fact that it came from the question: 'how do you deal with 14 different departments and one working board which was sort of thrown together as an amalgam of organizations and then called the Health and Human Services agency, comprised of people who have labored long and hard, and went to school and got degrees, and have mired in distinctly different disciplines, and work in proverbial silos every day, and don't know how to talk to each other?' You know, how do you create the proverbial hook, upon which they can hang their collective hat, in terms of dealing with a common constituency, and needs of a common constituency, and that really was for us the framing of the challenge of providing leadership for the agency.

We ultimately came up with two sorts of initiatives. This is one. And also a community and faith-based initiative. And in many ways, they were sort of default positions from where we wanted to start. We really wanted to start with the notion that government really doesn't directly help any-

body. I mean, it doesn't really do the heavy lifting ultimately. Government is a great funder, government can set the context, government can set the regulatory framework, but at the point of service, at the point of impact, it really doesn't, it really is not provided by government, it's provided by someone, other organizations outside of government, i.e., non-governmental organizations.

But yet, when we look at the work of government, we don't think about that critical relationship. We think about these as two separate worlds that have no intersection, yet we know that the success of government is contingent upon, and dependent upon, the work of people in the non-governmental sector. You name it, it happens. Nutrition, you name it in terms of health care, you name it in terms of social services, you name it in terms of education, there's a whole range of areas that we rely upon, normally through contractual relationships, with non-government organizations to do the heavy lifting of the point of service. And when we get in a panic and get criticized, we tend to just create another request for proposals or notice of fund availability, to fund some of these organizations that operate on shoestrings.

Now, we also talk about the fact that we don't want to invest in their administrative overhead. We want to invest in direct services. Yet we don't blink an eye when it comes to our employees at the state or the federal level, or local government level, in terms of investing in their capacity, in the technology, in the resources. Yet we expect these organizations that live on shoestrings that are critical to our success, to operate as if they don't need the same kinds of investments. So we sort of are somewhat hypocritical, to say the least, when it comes to the discussions of capacity building. And so our initial desire was to reverse that emphasis, was to begin to re-examine the way in which we relate to these non-governmental organizations that, for the most part, tend to be community-based, and in many cases, are non-profits. To try to encourage local government and our own programs to think about ways in which we can invest in their capacity, in order to do the heavy lifting on our part.

Now, you know, in economics, there's this notion of what's a public good? You know, and the classic definition, I think, of Samuelson, is that it's service provided by public employees, and fundamentally, consistently to everybody. It was sort of 'one size fits all.' That's basically the definition, the classic definition by economists, of a public good. And we said, we want to change that definition. We want to blur the distinction between the public and the non-public sector, if you will, the non-governmental sector. And we wanted to say that a service doesn't have to be provided by a government employee, and it doesn't have to be provided and it shouldn't be provided, in a 'one size fits all.'

And then, the other thing that we wanted to emphasize is the fact that our tasks ought to be, and the indicator of our success ought to be, "Are neighborhoods and communities stronger internally when we leave than they were when we came?" because the political verities, the political dynamics change, as we've seen, for example, in California. The point, though, and we recognize it, the point is that communities are there, and their fortunes are constantly in play. But the key for us was can we give them greatest capacity to self organize and to self regulate?

So the framework that we wanted to operate on is an old framework, going back to the 1960s. You remember; some of you may not remember. This is not history for me, because I was actually around. I was younger, but I was around. In the Johnson administration...there [was] a whole question of [whether] community action programs [should be]...a key element of the war on poverty. They had two schools of thought that they were debating internally. One school of thought said that we should emphasize what Michael Katz, historian, said, improving the poor

through the notions of interventions, you know, social services, job training, the whole host of things, to improve the poor, in other words, they're flawed, so improve them.

Another school of thought said that that's not where we should start. We should start with the notion of what we call now empowering them. Let's give them the resources, give them access to other resources like legal services, and then let them see what the priorities are that ought to be reflected in the interventions that they design and that they push. It was the latter that initially prevailed. When the Nixon Administration came into play, three years later, and Mr. Agnew was Vice President, they decided that this was an untenable approach. Why? Because they were getting complaints from urban city mayors and governors, that they could not control these free agents that were contracting directly with the federal government and were making demands upon public and private institutions.

I remember coming down here in 1970, to meet with the Oakland Economic Development Corporation—you may remember Percy Monroe and those folks—to talk about stopping the redevelopment project in Del Paso Heights, where I'm from, because of our fear of legal removal, as we called it in those days. What happened was the Nixon Administration reversed that because they felt that to empower the poor is to empower loose canons. So the discussion the panel focused on and what this document focuses on—empowering local communities to begin to identify their priorities, and to focus on crucial pathways that if addressed, can lead to measurable improvements in the material health of individuals and communities—is the right focus. But it is not controversy-free. And the one problem we have in public health is that when we have these discussions we talk about it as if this is apolitical. Well, friends, politics is nothing more than about the allocation of finite and scarce resources. That's all politics is.

So the discussion of redistribution of reallocated resources, of changing the relationships of power, it's a political discussion. It's a political endeavor. And to think that that can be achieved, without conflict, without tension—creative conflict, creative tension, I would hope—is to be somewhat, I think, ahistorical, in one's view. I won't say naïve. I'll say politely, ahistorical, because it doesn't reflect the countless decades of history.

Now, one of the things that we did, when I first came on, we brought John Frank, who at that time was a visiting professor over at Rutgers School of Public Health, who first introduced me to this concept of social determinants of health, back in 1997. And we felt that that was a perfect framework to begin to get 14 departments to think about health in the broader sense. That it's not just about good medicine, as important as it is, it's not just solely about expanding health care coverage, as important as it is. It is important to address relative inequality, or, if you will, relative deprivation. At the heart of this framework is that notion, vertical and horizontal, individual and group equality.

And so issues like land use can trump the most eloquently designed anti-poverty strategies if people are socially marginalized, and isolated, and can't get to employment and have no mobility. We see that in L.A. with the bus strike. I spent 14 years on the transit board in Sacramento. I get mobility. But mobility is not just about getting in the car or a bus. It's about getting from one place to another, to engage in day-to-day interactions.

So how you design neighborhoods—whether or not a kid or a senior has to have a car in order to get from one place to another. Why do children have to go to malls? I asked my daughter this. "Why do you guys go to malls?" It was simple. "You know, we can get there. It's enclosed.

They've got security guards. And there's a whole lot happening, and it's safe. And there aren't many other options." And so the fact that we force our children to go to malls for recreation should speak volumes about the poverty of resources and activities available to our children, in terms of their development.

My 90 year old grandmother has to be driven someplace because she doesn't have a driver's license because the neighborhood where she lives is not walkable. We don't build homes that have auxiliary flats or granny flats, like we used to before World War II, so that they could move in with you or if you're starting out as a young couple, you can make an income stream. If you're marginally income, in terms of earned income, in terms of assets, then why shouldn't we allow them to accumulate, not only equity in the basic primary home, but also to be able to become bankable, to count the potential income from a renter who rents above the house or in the back. But we don't design communities with that thought in mind. So therefore they're less affordable. Now, that may not be directly health, but I will submit to you, I would much rather have a house, be employed, and have an income stream, and not have health insurance, and try to tackle that phenomenon, than not have a house, not have a job, and not have an income stream. It does make a difference in terms of how you see the world.

So the community, faith-based initiative in this framework really attempts, on our part, to begin to change the way in which we frame the challenge of addressing relative inequality in the state. And allowing the ability for those of us to talk about public health, to understand two of the domains that we'd been concerned about.

You've heard discussion in environmental policy and land use policy about the three E's, right?—the economy, the environment, and equity. It's important, we would submit, to think about those terms, in terms of the domains as interacting, in terms of building a sustainable, political, majority because people involved in land use and environmental policy, and economic growth policy seldom think about health and seldom think about social equity. But if you begin to understand—I think PolicyLink has a pretty good handle on this—if you begin to understand the intersection, potentially, of those three domains, and the people who are involved in those domains, then in terms of public policy agenda, you can begin to connect the proverbial dots, in terms of common interest, in terms of common, common understanding. In terms of a common vision of what kind of community do you want to build at the end of the day?

Part of the problem is that our conversation is a negative one. We can talk about what we don't want to see. We have a difficult time talking about what we want to see. It is important, therefore, in a conversation, to broaden the scope of folks who are involved, with whom we interact, to identify a shared vision for this country.

Now, let me say something that may sound heretical and contradictory. I am not one who really firmly believes and is convinced that in the market economy, which is predicated upon winners and losers, that true equality can be achieved. I'm still not convinced that in fact it's possible, in a market economy, to achieve true equality. I am convinced and hopeful that we can narrow the band of inequality, of relative deprivation, significantly. Now, if you want to achieve true equality, that's another discussion, which I'm not going to have here, because I'm looking for a job, and I don't want to scare the employers away.

So I really do think that the framework is also one that doesn't require any one sector to have exclusive ownership. It is an ownership, but should be embraced, hopefully, by folks from all dif-

ferent sectors. That's why it is not published as a 'government document.' It is a coalition, a collaborative. And the idea, the task now is to popularize the concepts, because until people begin to understand and internalize the concept—and by the way, I really do believe it has to be done on an existential basis—we have to be able to understand the framework well enough so that when we talk and engage the uninitiated that we can really convey to them in a way that they understand and resonates with them.

And this is a tremendous challenge, by the way, that they can begin to embrace the concept, in terms of where they are, and in terms of what they see. And yes, some of the panelists talked about that. And so our job is not to hand them the document. Our job is to have the document as a reflective source, for us to think about putting our organizing hat on. How do we frame various challenges and various issues in order to begin to expand the number of folks, everyday Californians, who embrace intuitively and internalize this framework, so that it becomes almost second nature? They don't have to understand the terminology or the jargon, just the concepts. Just the concepts. You know, the notion of...like my mother used to ask her doctors, "Where'd you go to school? Why are you recommending this treatment for me? Are there some alternatives? What are the side effects?" She was doing this in the '60s, and I said, "Gee, she's smart." And she was just a high school graduate, a keypunch operator. But she had enough understanding, and was not intimidated by somebody with a degree, and she was concerned about her kids to the point that she wasn't about to put their fate in the hands of somebody until she was assured they knew what they were doing. There are a lot of people like my mother out there. And the key is to help them understand that they're not crazy, they shouldn't be intimidated, that, in fact, they have the right and the responsibility to pose these kinds of questions from their perspective, from the standpoint of their interest—individual, familial, and collective.

And so if you ask me what the next step is, that's the next step, to begin in different domains that is, in the public sector, in the private sector, to get folks to understand these concepts, and to begin to be informed in terms of their practice by this framework. That's the next step. And it requires folks in this room, and folks outside this room, to in fact do that.

I'll end at that point. Thank you.

BOB ROSS

Grantland mentioned his co-chair in this effort was Georges Benjamin. I also want to acknowledge Mohammad Akhter who is here. He's the brainchild of this. Mohammad, former APHA Director. Thank you, Mohammad.

I just want to say, on behalf of all these panelists here, but certainly those of us at The California Endowment, there are a lot of foundations that pride themselves on having their work directed by the evidence and the data. I am very proud and comfortable, and I am re-inspired to say that our work is guided by values and leaders. And it is the leadership of these kinds of individuals that we have relied upon, Marion and I in particular, to think about our disparities program. This document becomes the blueprint for our disparities program. Thank you to the extraordinary leadership of this panel, and thank all of you for being here. We appreciate it.